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IN AFFILIATION WITH
THE CANADIAN MEDICAL ASSOCIATION
THE BRITISH MEDICAL ASSOCIATION

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The Manitoba Medical Association Review

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CLINICAL MEETINGS

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At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital—
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during College Term.

Winnipeg Medical Society—
3rd Friday, Medical College, 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Bldg.

Clinical Section

*THE TOXAEMIAS OF PREGNANCY

By

ROSS B. MITCHELL
B.A., M.D., C.M. (Man.), F.R.C.P. (C.)

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Senior Obstetrician to the Winnipeg General Hospital.

AT the very outset of a discussion of the toxaemias of pregnancy it must be admitted that the subject is obscure and that there is much of which we are profoundly ignorant. Indeed the very term, 'toxaemia' begs the question. There are those who deny that the disorders grouped under the heading of toxaemias of pregnancy are due to circulating toxins. All that we can say is that the toxaemia theory fits in best with observed facts, and that the pathological findings in these complications of pregnancy coincide with those found after the exhibition of known toxins, *e.g.* cobra venom. If the theory of toxaemia is admitted we do not know whether there is one toxin or several, whether the toxaemic states are, or are not, exaggerations of conditions found in every pregnancy, from what source the toxin springs, or how the various endocrine glands affect the condition. Since true eclampsia does not occur spontaneously in animals, the results of animal experimentation in this field, must be received with caution. In discussing the toxaemias of pregnancy the truth of the axiom of Hippocrates is borne in on us: "Judgment is difficult and experience fallacious."

Having made these admissions we can state that the subject is one of grave importance, that our knowledge is being extended, and that watchful scrutiny based on knowledge and experience will do much to save human life and increase its happiness. How complex the subject is may be inferred from the fact that the desire for reproduction comes second only to self preservation as a motive of action, and that pregnancy affects profoundly the whole maternal organism. In the life of woman pregnancy is the great experiment. In addition social and economic factors operate powerfully in the causation of toxaemic states, and these factors are largely out of the control of the doctor.

An audience such as this does not need to be reminded of the clinical features or the pathological findings of the various forms of toxaemias. Since the object of this clinical week is to make the various discussions as practical and helpful as possible, let me set before you experience gained in the prenatal clinic and public wards of the Winnipeg General Hospital and from private practice. May I here lay down certain general propositions.

*Clinical lecture read at the Manitoba Medical College Post-Graduate Course, May 18, 1934.

1. The more complex and luxurious the society the greater the incidence of toxaemia.

2. Toxaemia is more frequent in primiparae, *i.e.* those who have not before been subjected to the most delicate test of efficiency of organs concerned in metabolism which is pregnancy.

While the physician can do comparatively little to control the incidence of toxaemia in the mass he can do much for his individual patient, first by lessening the possibility of toxaemias occurring, by giving sound advice, secondly recognizing departures from the normal when they occur, and thirdly preventing toxaemias from proceeding to their graver forms.

In this complication of pregnancy an ounce of prevention is worth a pound of cure. It is too much to expect, with our present lack of knowledge, that toxaemia can be wiped out, but it is not unreasonable to believe that eclampsia may become a very rare condition, and that the conscientious physician will regard its appearance in a patient under his care as a serious flaw in his management of the case. Precisely because in pregnancy we are dealing with the beginning of life, the most mysterious thing in the universe, we must not be narrow or arbitrary in dealing with its disorders.

Eclampsia has been called the disease of theories. Without further discussion of the aetiology of the toxaemia of pregnancy all I can say at this time is in the words of Cruikshant, Hewitt and Couper: "If the toxaemias of pregnancy have a common cause it is some form of intoxication by the breakdown products of placental tissue, probably some of the higher products of protein katabolism which have a powerful action even when present in small amount".

What is the magnitude of this problem of pregnancy toxaemias in Manitoba? The answer is found in the fine article by F. W. Jackson, R. D. Defries and A. H. Sellers in the March number of the *Canadian Public Health Journal*. In a five year survey of maternal mortality in Manitoba, 1928-1932, there were 71,651 births and 364 maternal deaths. Of these 84 were due to puerperal albuminuria and eclampsia and 18 to pernicious vomiting. Toxaemias therefore accounted for 102 deaths or 28% of the total. The toxaemias ranked first as causes of maternal death. In the ten year survey of patients in the public wards of the Winnpieg General Hospital from July 1, 1923 to June 30, 1933 there were 5,339 births and 17 deaths from puerperal causes, and 7 of these, including one case with chronic nephritis and 7½ months pregnancy, moribund on admission, were due to toxaemias of pregnancy. Of these 7 one died of eclampsia 40 minutes after admission, another 9 hours after admission, two of acute

yellow atrophy of the liver fully developed on admission, one of pernicious vomiting of pregnancy, one of chronic nephritic toxaemia and Caesarean section done as a last resort leaving only one case which died of eclampsia after treatment. Of the total admissions to the public ward in the ten years 1 in 15 showed some evidence of toxaemia. Since the toxaemias attack primiparae particularly, it is the younger women who were killed. Then too toxaemias are a frequent cause of maternal morbidity, illnesses sometimes of a permanent nature. Of all the maternal diseases of pregnancy toxaemia is the most fatal to the child. Holland, investigating 301 foetal deaths showed that 26 per cent were caused by albuminuria, eclampsia or accidental haemorrhage. Moreover, many children born of toxaemic mothers succumb within the first weeks of life.

In the textbooks of obstetrics much space is devoted to the management of cases of eclampsia and hyperemesis gravidarum. Doubtless that is necessary at the present time but in up to date teaching more and more emphasis must be laid on prevention and prevention means early recognition of departure from the normal of pregnancy. This implies that we must know not only what constitutes normal health in the adult woman, but also what changes occur in a healthy woman as a result of pregnancy.

The later stages of pregnancy are a period of relatively low nitrogenous metabolism, a considerable proportion of the ingested material being stored for the needs of the foetus and in preparation for lactation and comparatively little excreted. Urea, the chief end product of protein katabolism, is therefore formed in relatively small amounts, and the urea content of the blood tends to be lower than normal. The urea content of the urine is reduced relatively to other nitrogenous constituents. Considerable storage of inorganic salts also takes place, notably calcium, phosphorous and magnesium. These stores are utilized by the foetus largely, of course, for bone formation and if the diet is adequate in these salts the mother terminates her pregnancy with a slight gain in calcium and a considerable gain in phosphorous. If, however, the diet is poor in these substances, as is often the case with town dwellers, the foetus draws stores from the reserves in the mother's bones and teeth. The fat and cholestrin content of the blood is increased during pregnancy, falling to normal with the onset of lactation. Some observers have thought that there was a marked degree of biliary stasis but de Wesselow and Wyatt declare that it is not yet possible to state that the hepatic function is impaired in a normal pregnancy. In 30 to 50% of pregnant women the kidney is abnormally permeable to glucose, and glycosuria occurs when the blood sugar is well below the normal renal threshold. The significance of this observation is doubtful, but it is at any rate suggestive of an alteration in the renal function even in pregnancies which are otherwsie perfectly normal. In pregnancy there is a tendency to an hydraemic plethora. The solid content of the serum is diminished, its water content is increased, and there is a moderate rise in the total blood volume. The cause of this condition is unknown, but it may indicate a slight defect in the capacity of the kidney for water excretion, a defect which in a much more marked form is characteristic of the pre-eclamptic and eclamptic toxaemias.

Even in normal pregnancies a slight acidosis is present, indicating some diminition in the alkaline reserve of the blood. Acetone bodies also appear to be produced more readily in pregnancy than in the non-gravid condition. Diets poor in carbohydrates which normally produce no excretion lead to the appearance of very definite amounts of acetone and diacetic acid in the urine of the pregnant woman, a fact which is of interest in connection with the very high output of these substances in pernicious vomiting. These changes in metabolism as a result of pregnancy indicate that during that state there is an instability which may readily pass over to the pathological. Thus retention of chlorides and exaggeration of the hydraemic plethora will give rise to oedema. The lowered renal threshold for sugar indicates that there may readily be disturbances in carbohydrate metabolism. In eclampsia acidosis is well marked; in pernicious vomiting the ammonia index or coefficient, that is the proportion of urinary nitrogen excreted as ammonia, is greatly increased and acetone bodies are invariably found.

Since any woman who develops eclampsia is seriously ill, even so gravely ill that death may result, and since many good authorities state that the only certain method of effecting a cure in true pernicious vomiting of pregnancy is to terminate the pregnancy, and that if this operation is delayed too long even it may not save the patient's life, and, further, since our knowledge of the causes of the toxaemias is so vague, it follows that the whole emphasis must be laid on prevention. While, of course, proper care in hyperemesis gravidarum and eclampsia is highly necessary the fact remains that many patients die even with the best care if that care is given only when the condition has supervened. Only when adequate and well-informed prenatal care is given to all pregnant women will the loss from the toxaemias be greatly reduced.

This statement must not be construed as a criticism of the doctors. The five year survey of maternal mortality in Manitoba already referred to indicates quite clearly that the majority of the women dying of toxaemia had never consulted a physician; in 55% there had been no prenatal care and in 6 the patients refused to cooperate. The Manitoba Department of Health has thus defined prenatal care: the regular and frequent examination of the urine from the fifth month of pregnancy onwards (or earlier), also estimation of blood pressure from the fifth month (or earlier) and estimation of pelvic

measurements not later than the eighth month as well as general care and advice. Through the provincial Department of Health, the federal Department of Health or through private firms excellent booklets or letters giving advice to pregnant women can be procured and when the doctor is first consulted by a maternity patient he should see that his patient obtains one of these booklets or the series of monthly letters. It is true that he may give excellent advice but that may be forgotten or misunderstood and the printed word, always available, is preferable to the spoken word.

Any pregnant woman with a systolic blood pressure of 140 or over, and with urine presenting even the faintest trace of albumen should be regarded as a potential toxaemic and should receive additional care. One does not wish to alarm patients unnecessarily but I think we have all erred in the past through deferring active treatment of toxaemia too long. A few days rest in bed with restriction of diet and a saline purge as soon as any symptoms are manifest will often tide a woman over the danger point so that she is able to go on to term. Similarly if, in the earlier months of pregnancy, a woman reports that she is vomiting after every meal, and especially if her weight is decreasing and acetone is present in the urine, she should receive treatment. I am firmly convinced of the great value of glucose in this condition in dilutions of 10% or even higher, preferably given intravenously. Along with glucose medication, sedatives such as the bromides or sodium luminal, which may be given per rectum, are a great help. In severe cases morphine or heroin may be given hypodermically. If rest in bed, absolute quiet of mind and body, the exhibition of glucose and sedatives, and withholding all food by mouth for 48 hours do not allow the patient to retain the simple food taken by mouth, the question of terminating the pregnancy should be seriously considered. A consultation is usually advisable in such cases.

The social and economic factors are often times beyond the control of the doctor. The recent arrangement between the doctors and the municipalities in Greater Winnipeg and the arrangements that prevail in certain rural municipalities of Manitoba whereby patients on relief or indigents can receive medical care at the expense of the municipality, should be a long step forward in the prevention of mortality from the toxaemias.

A comparison of the patients in the public maternity wards of the Winnipeg General Hospital who received adequate prenatal care and those that did not show that the latter class were 8 times more liable to develop eclampsia. This is an illuminating fact and indicates that watchful care of every pregnant woman by her physician will do much to save life or prevent illness which may become permanent.

HYPNOTICS AND ECONOMICS

By

M. J. ORMEROD, M.D. (Tor.)

Assistant Professor of Physiology and Pharmacology and Lecturer in Therapeutics
University of Manitoba.

Introduction.

MORE wrong prescribing is done for sleeplessness than for any other common complaint. A great measure of this is due to the failure of the physician to ascertain the exact cause of the insomnia and to use an appropriate drug where required. It is not my intention to go into the various underlying factors in insomnia, other than to divide it into cases due to a pain factor and cases lacking this background. In the latter case, true hypnotics are called for: in the former an analgesic with or without the addition of a hynotic. Failure to recognize the basic fact that hypnotics do *not* relieve pain is responsible for wasted time and money of the patient. Thus, 40 grains of chloral would not cause sleep in the presence of even mild pain, while 5 or 10 grains of Acetylsalicyclic Acid will give prompt relief.

A second point in the use of hynotic drugs which leads to even greater wastage of money is the persistent foisting upon the profession of high-priced proprietary preparations under fancy names. It might be worthwhile at this point to consider the relative costs to a patient of various hypnotic drugs. The figures given were kindly supplied by a representative local retail druggist.

TABLE I.

Drug	*Amt. per Unit*	*Price per Package*	*Price per Dose*
Chloral (Syrup)	10 grs. per dr.	3 oz. ..... $ .65	3 to 4 cents
Triple Brom. (Tab.)	22 grs. per tab.	1 doz. ..... .35	3 cents
Triple Brom. (Elix.)	10 grs. per dr.	3 oz. ..... .65	5 to 8 cents
Carbromal (Adalin)	5 grs. per tab.	1 doz. ..... .75	6 to 18 cents
Soneryl (Neonal)	1.5 grs. per tab.	1 doz. ..... .45	4 to 8 cents
Dial	1.5 grs. per tab.	1 doz. 1.00	8 to 25 cents
Luminal	1.5 grs. per tab.	1 doz. ..... .60	5 to 10 cents
Medinal	5 grs. per tab.	1 doz. ..... .40	3 to 7 cents
Allonal	1.5 grs. per tab.	1 doz. 1.50	25 cents
Nembutal	1.5 grs. per tab.	1 doz. 1.00	8 to 17 cents
Phanodorn	3 grs. per tab.	1 doz. ..... .75	15 cents

The prices quoted on Luminal and Medinal may be materially reduced if the B.P. names Phenobarbitone and Barbitone Soluble are substituted in the prescription.

The doses of the above drugs have been estimated to give roughly equivalent effects.

An ideal hypnotic would possess the following attributes:

1. Prompt and efficient action.
2. Minimal medullary depression.
3. Minimal or no gastric irritation.
4. Pleasant odor or taste.
5. Rapid elimination or detoxication.
6. Freedom from addiction.

As in so many other cases, the ideal is still to be found. If we analyze the various drugs quoted in the table, however, we find that some approach the ideal fairly closely.

Chloral.

This drug is our earliest and, I believe, still our best hypnotic. It has acquired a bad name mainly because of misuse, and because of misinterpretation of animal experiments. It is freely soluble in water, has a rather penetrating odor and taste, is irritating to the stomach if not well diluted. Addiction has been greatly over-written: it is relatively rare and need not exist at all if the physician marks his prescription "N.R." to prevent unwarranted repeats. Chloral has been a familiar bugaboo as regards depression of heart and respiration, and damage to liver: these are misinterpreted animal results, and the scare disappears when dosages are maintained at therapeutic levels. Doses of 30 to 45 grains may cause serious damage: dosages of 10 to 15 grains are nearly always sufficient and can be given over fair periods of time, even in cardiac disease.

For Example:

Rx Chloralis Hydratis gr. x
Aqua ad ℥i
Sig ℥i ex hot milk at h.s.

The drug acts within 10 to 15 minutes if given in hot milk at bed-time, the sleep is deep and well-maintained, and detoxication and elimination are complete in a few hours, so that the patient feels refreshed on waking, and has no "hangover." Medullary depression with this dose is no greater than in natural sleep. If the above dose is not sufficient, an equal or greater amount of bromide may be prescribed with it with advantage.

The prescription from the Canadian Formulary—Mistura Bromidi et Chloralis—may be used.

Rx Chloralis Hydratis
Sodii Bromidi ana gr. xv
Extracti Glycyrrhizæ Liquidi
Elixir Aromatici ana m.xv
Spiritus Coriandri C.F. m.i
Syrupi ad ℥ii
DOSE – ℥i to ℥ii

Bromine Derivatives.

The simple alkaline bromides are the commonest. Sodium bromide is most pleasant, potassium bromide next, and ammonium bromide is the most irritant. Strontium bromide is a vanishing drug without any special value over sodium bromide. All are water soluble and not very pleasant in taste. They are non-irritant to the stomach, cause no addiction, but occasionally cause skin rashes. Excretion is slow, hence the action persists longer than chloral and leaves a definite "hangover." There is no medullary depression. Doses of 15 to 30 grains are safe over long periods. *Carbromal* is a complex bromide derivative, practically tasteless because of its insolubility. It is non-irritating to the stomach, and indeed finds its best use in insomnia due to nervous dyspepsia. Excretion is slow enough to leave some mental cloudiness in the mornings. Doses of 5 to 15 grains are common. Occasionally severe itching follows its use. *Bromural* is another bromureide quite similar to carbromal in action, but much weaker. Doses of 5 to 15 grains act in 5 to 25 minutes in mild cases.

Paraldehyde.

This is a liquid of rather vile taste and imparts an equally unpleasant odor to the breath all the next day. It acts promptly and safely, but is less certain and powerful than chloral. Small doses have no side actions: large doses cause irritation of mouth and throat and some faintness. There is only a slight medullary depression even with large doses. Tolerance and addiction are not uncommon. Toxicity is low: 3 ounces have caused only a very deep sleep. It is most, and probably best, used in alcoholic or other dementias.

Sulphones.

Sulphonal and Methylsulphonal (Trional) are the usual ones. Sulphonal acts in 1 to 5 hours, methylsulphonal in ½ to 1 hour. Both are excreted slowly and the danger of cumulative poisoning is considerable, even with small doses, unless the drug is remitted 1 or 2 days a week. Poisonings with sulphones have a poor prognosis: unless the drug is stopped very early, death may occur after weeks of exhaustion. All in all, they are not efficient enough to outwiegh their possible dangers.

Barbiturates.

With apologies, I misquote: "Of the making of barbiturates there is no end," because barbituric acid happens to be bi-valent, shrewd chemists have seized the opportunity to attach innumerable variations of chemical groups to the acid, each variation being gorgeously named, fancily packaged, thoroughly patented and superlatively priced. A partial list follows:

TABLE II.

B.P. or Patent Name	*Chemical Constitution*
Barbitone ("Veronal")	Di-ethyl-barbituric acid.
Barbitone Soluble ("Medinal")	Sodium-diethyl-barbiturate.
Phenobarbitone ("Luminal," Gardenal")	Phenyl-ethyl-barbituric acid.
Phenobarb. Soluble	Sodium-phenyl-ethyl barbiturate.
"Dial"	Di-allyl-barbituric acid.
Pentobarbitone ("Nembutal")	Ethyl-methyl-butyl barbituric acid.
"Pernocton"	Butyl-brom-ethyl barbituric acid.
"Soneryl" "Neonal"	Butyl-ethyl-barbituric acid.
"Phanodorn"	Cyclo-hexenyl-ethel barbituric acid.
"Evipan"	Dicyclohexenyl-N-methyl barbituric acid.
"Veramon"	Amidopyrine plus barbitone.
"Allonal"	Amidopyrine plus allyl-isopropyl barb. acid.
"Somnifen"	Barbitone plus allyl-isopropyl barb. acid.
"Ortal-sodium"	Sodium hexyl-ethyl-barbiturate.

Proprietary names are in quotation marks in the above table.

The barbitrates have this in common: they cause practically no gastric irritation or medullary depression in hypnotic dosage. Most cause a "hangover" because of slow excretion or detoxication. Addiction is common and easily acquired because these preparation do not require a prescription. Skin rashes are not uncommon. Cumulative poisoning is easy in many of them with slow excretion, unless the drug is intermitted one or two days a week. They are fairly good hpynotics and poor analgesics, hence should not be used as other than hypnotics. Individual dosages vary widely, as do the responses: many patients have a preliminary period of excitement or mania before hypnosis sets in. "Evipan" is the newest, and from preliminary reports, the best hypnotic among them. It causes sleep in 10 to 20 minutes, in doses of 4 to 8 grains by mouth, and the drug is completely detoxicated by the liver in 4 or 5 hours, thus permitting its use in the early hours of the morning, even, without any cerebral clouding the next day. It has very little effect in hyperthyroid states. Such proprietaries as "Allonal" and Veramon" are unscientific since the two components vary widely in excretion rates and cumulative barbituric poisoning can be expected: a much more logical method is to prescribe hypnotic and analgesic separately, and so control dosage absolutely.

Summary.

With this rather hurried review in mind, it becomes easy to make a decision as to the economic side of hypnotics. Chloral, the most efficient and certain, and the cheapest, is obtainable only on prescription. There is no fancy "overhead" tacked on the price to cover the activities of inspired advertising men, persistent detail men, and free samples. On the other hand we have the numerous proprietaries laden with all this overhead, not requiring a prescription, and so easily forming addicts. The physician himself is responsible in very many cases. These "free" samples are handed out by him to patients, in the original packages, and if the patient finds relief from their use, he goes back, not to the doctor but to the druggist, for a renewal, asking for the preparation by its patent name. The fault lies here entirely with the medical man, not the pharmacist: as a matter of fact, the latter would infinitely prefer ethical prescriptions using common drugs to self-medication with expensive proprietaries. The moral is obvious, if the medical profession really wishes to control the drug usage of the public.

TRIGEMINAL NEURALGIA

THE DENTAL ASPECTS

By

H. J. MERKELEY, D.D.S. (Tor.), M.D.S. (Tor.)

Demonstrator in Dental Surgery, Faculty of Medicine, University of Manitoba;
Examiner, Dominion Dental Council.

Dr. Corrigan's article dealt very fully with the subject from the medical and surgical standpoint, but I believe there is sometimes a dental aspect that should also receive attention.

The three divisions of the fifth nerve in their distribution pass through bony channels of some length, and an impingement on the nerve trunk can be and often is demonstrated, and it is of interest in this connection that this severe neuralgia is limited to the fifth nerve.

I have seen cases which exhibited the true clinical syndrome of tic, in which some impingement on the nerve trunk by roots of third molars, other impactions, or roots have been found, and when these were removed the clinical symptoms were relieved either permanently or for a period varying from one to five years.

There is one important point. Even routine x-ray of the jaws with intraoral dental films may miss certain third molar impactions. Head plates are more reliable.

In the mandible, the location of the nerve canal lends itself to impingement from not only the third molar but the other molars as well.

In the maxilla the third molar area and the infra-orbital canal have to be considered.

My records indicate that the removal of root fragments impinging on the canal in the mandible has relieved tic for some years, where a previous section of the nerve trunk at the angle had given relief for only a year or so. Occasionally the third molar roots straddle the canal, and as calcification proceeds tend to constrict the passage, or again impacted lower molars may displace the normal canal. We sometimes find that extraction in these cases will give relief, but in older patients the root sockets may calcify in and so perpetuate the condition present before the roots were extracted. Good practice would seem to indicate a removal of the wall of the socket where it may impinge at all.

In the maxilla, the teeth can of course not interfere with the infra-orbital nerve, but can in the third molar and cuspid area displace the secondary branches of the second division.

It would seem that, if the alcoholic injection at the mandibular foreamen can relieve a tic, then the origin of pain must have been anterior or in the mandibular canal. The indiscriminate extraction of teeth should not be suggested, but I believe that impingement of roots as well as fracture cases do constitute a cause in at least a small number of cases of trigeminal neuralgia.

Cases.

1. Mr. B. first seen in January, 1921, had had recurrent attacks of tic until the inferior dental nerve was severed at the angle of the jaw, a year or so previously. Relief given for approximately a year. Was referred for an intraoral section but x-rays disclosed what seemed a root fragment of a first lower molar impinging on the inferior dental canal. Root removed and complete relief obtained for approximately five years, when pain returned. Another extra-oral operation was performed on the ascending ramus and the nerve again severed and relief given for another year, when patient died from other causes.

The recurrent symptoms here, after the removal of the root, were I believe due to the socket calcifying in, thus renewing the same condition that existed before the extraction. A removal of the whole impinging wall would no doubt have been better procedure.

2. Mr. C., patient age 65, presented, having considerable swelling in the upper cuspid region. Had a gasserion resection done for a tic some time previously. Had worn a full upper artificial denture for some years. X-rays revealed an abscessed impacted upper cuspid.

The tic in this case was no doubt due to an exposed and irritated pulp (nerve) in the cuspid which had decayed, although entirely hidden.

3. Mr. H., age 45, complained of violent neuralgia present for a year, gradually increasing in intensity until it almost simulated tic. X-ray disclosed an impacted lower third molar. Extraction revealed the nerve trunk passing through a foramen made by the bifurcate roots. Anæsthesia persisted for about a year but no return of neuralgia. This case I believe would have developed into a true tic had extraction not been made.

OBITUARY

DR. EUGENE WALTERS, aged 69, died at his residence in Winnipeg on May 9th, after a long illness. Born in London, England, he was educated as a missionary and in 1887 went to a mission field in Jamaica. He graduated in medicine in 1896 from the University of Minnesota, and in 1903 came to Winnipeg where he established a clinic in North Winnipeg and later served on the staff of Victoria Hospital. Throughout his life he remained devoted to the Baptist Church.

Editorial and Special Articles

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Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association.

MANITOBA MEDICAL COLLEGE GOLDEN JUBILEE

THE celebration of the fiftieth anniversary of the founding of the Manitoba Medical College and post-graduate course associated with the celebration have both been successfully concluded.

The post-graduate course apparently was considered to be useful by all those attending. It is understood that the committee in charge of the course intend to review the results and then submit a questionnaire to those who have attended in order to make any changes that the practitioners may suggest for next year.

In addition to the meetings of the Canadian Medical Association, the organized medical societies and the Faculty of Medicine now provide for the interchange of knowledge and experience among medical men in Manitoba and the adjacent provinces by:

1. The regular meetings of the district societies and hospital staffs.
2. The annual meeting of the Manitoba Medical Association.
3. The provision of special speakers at the meetings of the district societies.
4. The publication of short articles on clinical subjects in the *Manitoba Medical Association Review*.
5. The circulation of books and journals from the Medical Library of the Faculty of Medicine and the College of Physicians and Surgeons.
6. The post-graduate course provided by the Faculty of Medicine, which will now become an annual event.

It is possible that the meeting of the Manitoba Medical Association and the post-graduate course might usefully be combined into a single week. There is one deficiency in the annual meeting of the Manitoba Medical Association, which might with advantage be corrected. The rural practitioner has neglected to prepare and read papers giving the results of his special experience. If the rural practitioner could find the time to prepare such papers, it would benefit himself by summarising and clarifying the knowledge resulting from his own experience, and also would make available for the specialist in the larger centre this knowledge which is denied to him as a result of the limitations imposed by his practice. It is worth recalling the fact that the greatest contribution to modern knowledge of heart conditions was made by Sir James Mac-

Kenzie as a result of his experience and observations while a general practitioner at Burnley. It might be possible to make papers by rural practitioners a feature of the September meeting of the Manitoba Medical Association.

C. W. MacC.

MINUTES OF EXECUTIVE MEETING

MINUTES of a Meeting of the Winnipeg Members of the Executive of the Manitoba Medical Association held in the Club Rooms of the Medical Arts Building on Wednesday, May 9th, 1934, at 12:30 noon.

Present:

Dr. J. C. McMillan, Chairman
Dr. J. S. McInnes
Dr. F. G. McGuinness
Dr. Ross Mitchell
Dr. R. R. Swan
Dr. W. W. Musgrove
Dr. F. A. Benner
Dr. A. G. Meindl
Dr. F. W. Jackson

Workmen's Compensation Board.

Letter from the Workmen's Compensation Board, under date of May 5th, was read, stating that it was their opinion that two members should be appointed to the Medical Appeal Board, each for a term of two years.

It was moved by Dr. F. G. McGuinness, seconded by Dr. Ross Mitchell: That the new arrangement, suggested by the Workmen's Compensation Board, be approved. —Carried.

Medical Relief in Rural Manitoba.

The Secretary read draft of letter which it was proposed to send to all rural practitioners, also draft of letter proposed to be sent to the various municipal councils, with reference to medical relief to indigent persons.

It was moved by Dr. F. A. Benner, seconded by Dr. Ross Mitchell: That these letters be approved and forwarded. —Carried.

Annual Meeting.

PLACE:

Moved by Dr. F. G. McGuinness, seconded by Dr. R. R. Swan: That the meeting this year be held at the Royal Alexandra Hotel, Winnipeg. —Carried.

TIME:

Moved by Dr. R. R. Swan, seconded by Dr. W. W. Musgrove: That the dates of the meeting be September 10th, 11th and 12th. —Carried.

Conveners of Committees:

The following were appointed as Conveners of the various committees for the Annual Meeting:

Hotel, Reception and Auto	Dr. A. G. Meindl
Finance	Dr. F. G. McGuinness
Press and Publicity	Dr. Ross Mitchell
Scientific Exhibits	Dr. C. E. Corrigan Dr. F. A. L. Mathewson
Commercial Exhibits	Dr. F. W. Jackson Mr. J. G. Whitley
Entertainments, Dinners and Luncheons	Dr. R. R. Swan
Ladies' Committee	Mrs. J. C. McMillan
Programme	Dr. F. G. McGuinness Dr. F. A. Benner Dr. Ross Mitchell Dr. W. W. Musgrove Dr. F. W. Jackson
Resolutions	Dr. G. S. Fahrni
Registration and Tickets	Dr. F. W. Jackson

There being no further business, the meeting adjourned.

NEW METHOD OF NOMINATIONS AND ELECTIONS TO THE COUNCIL *of the* COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

The following are the new regulations governing the nominations and elections to the Council of the College of Physicians and Surgeons of Manitoba:

1. The Registrar shall (in 1934 or any election) not later than August 1st, mail to each member of the College:
   (*a*) A statement as to the constituency in which such member resides.
   (*b*) A list of the members of the College eligible for election to the Council, in the constituency in which such member resides.
   (*c*) A printed form to be known as the Nomination Form; which shall provide space for:
      1. The name of the constituency with name of present representative.
      2. The name of a member being nominated for election to the Council.
      3. Names of members of such constituency as nominator and seconder of such member.
      4. Notice that such nomination form must be returned to the Registrar not later than August 31st, in order to provide for nomination.
2. That in each constituency such members, as return (or have returned for them) to the Registrar, not later than August 31st, a Nomination Form properly filled out and signed by two members of the College (nominator and sec-

onder), eligible to vote in the same constituency as that in which the nominee resides, shall be declared to be duly nominated for election to the Council.

3. That in the event of only one member (or a just sufficient number of members to fill the vacancies existing) being properly nominated for election, such member (or members) shall be declared duly elected to the Council.

4. That in the event of no member (or an insufficient number of members to properly fill the vacancies existing) being nominated, from any given constituency or constituencies, the Council or its Executive Committee shall be empowered before September 15th, to name not less than two members (nor more than double the number of members of the vacancies existing) from such constituency, or constituencies, who shall thereby be declared to be duly nominated for election to the Council.

5. That the Registrar shall not later than September 15th, mail to each member of the College eligible to vote at election a Ballot Form, which shall provide space for:

   1. The name of the constituency.
   2. The names of the members nominated for election to the Council from such constituency.
   3. Such proper space as may allow the member voting to indicate his choice of nominee, or nominees to be elected.
   4. Notice that such ballot must be returned to the Registrar not later than September 30th, in order to be registered for the election.
   5. That on October 1st, or the first legal non holiday thereafter, the ballots shall be counted by the duly appointed scrutineers, who shall then declare to the Registrar, and through him to the Council, the names of the member or members from each constituency duly elected to the Council for the ensuing term.

W. G. CAMPBELL,
Registrar.

THE APPROACH OF SOCIALIZED MEDICINE

The following extract from the editorial pages of the *Bulletin of the Vancouver Medical Association* for October, is worthy of more than provincial notice. We would only add that the comments made in this editorial contain the courageous and fairminded reasoning that has always characterized our brother editor's writing. (Editor *Can. Med. Assoc. Journal*).

"We publish in this number certain correspondence between Dr. Routley and the British Columbia Medical Association relative to an interview held with Mr. R. B. Bennett, Prime Minister of Canada. Our readers will, no doubt, form their own conclusions on this matter. We feel that an advance has been made, in that Mr. Bennett has at least admitted the justice of our cause, but the extent of the advance reminds one of the bulletins which appeared daily from the battle front during the Great War, when "important gains" were announced. The actual results always seemed rather an anti-climax. And so it is with this. Our cause is just, but it is a case, apparently, where virtue is its own reward, and that is expected to be sufficient.

Dr. Routley appears somewhat more optimistic than we can at present justify his being. Nowhere does Mr. Bennett actually commit himself. He passes the buck back to the provinces. These are absolutely (at least in the case of the Western provinces) on their uppers, and will not contribute anything that they are not forced to give. So the prospect is not any too bright, unless we can find some other solution.

What are we to do in this emergency? Are we to be forced into the position where we must simply refuse to go on treating these unfortunate people? Suppose we did so refuse. That would, perhaps, force the issue, and might perhaps raise enough of a row to induce the authorities to find some money somewhere. It is a possibility, and we may yet be forced to it, if conditions persist as they are, or grow worse. But it will not be a solution. Even if some immediate financial result were obtained, it would not be a solution, it would leave much bitterness, and, like all wars, this conflict would leave a great many sore wounds in its train. Moreover, it would have another prejudicial consequence, it would establish standards of remuneration on entirely false bases, and these standards would undoubtedly be used to our disadvantage in future negotiations. Would it not be wiser to put the question to ourselves, whether the time is not now ripe for us to formulate an adequate and comprehensive scheme of medical care for the community, a scheme which would be not only fair to ourselves, but generous and profitable to the whole population? Expediency is never a safe guide, it is always accompanied by shadows of retribution. Consider the British Health Insurance Act, which took the easiest and opportunist course, instead of being designed on sound economic lines; during its operation vested interests have grown up and become entrenched, which make improvement well nigh impossible.

For good or evil the feet of our civilization are set on the path that leads to socialization of every department of life. For ourselves, we are frank to say that we think it is for good. But we must not halt and linger on the way, looking continually over our shoulders, in fear that we may have made a mistake. The words of Jesus, the Son of Sirach, the Preacher of Wisdom, are still true, and may well serve as our guide,

> 'Do nothing without counsel
> And when thou hast once done, repent not.'

What scheme then should we urge? Health Insurance? Of late, a grave doubt has been growing in some of our minds whether even this would go far enough, or would solve all the difficulties. Also, we may question whether it is a sufficiently generous plan, whether, perhaps, we have gone far enough in considering the needs of the public, or whether we have thought too much of safeguarding our own rights. We do not imply that the latter is not fair and desirable, but we would emphasize the fact that our interests and those of the public we serve are inseparable and that candor and generosity on our part will do more than anything else to restore the medical profession to the pinnacle on which it once stood, and from which to a great extent, as a profession, it has slipped."

MEDICAL ECONOMICS

The following is an article by Frederick B. Balmer, Ph.G., M.S., M.D., which should prove interesting to our readers:

The subject of Medical Economics has finally become recognized as an essential part of the practice of medicine. Some think it undignified for the profession to even consider the subject as a separate entity. Others think knowledge of medical economics and the art of the practice of medicine should be acquired by precept and example. But how could this be proper, since the vast majority of our preceptors have made a botch of just this phase of medicine and admit their shortcomings without compromise or reservation.

Believe me, this important problem is not going to be solved by ignoring the basic principles involved. That all generalities are subject to exceptions, there can be no doubt. Nevertheless, I believe the practice of graduating medical men on such a high moral and scientific basis as is being done today with an abundance of ability and knowledge to practice medicine and yet turn them out as innocent as newly born babes when it comes to their own economic and social welfare is one gap in medical education that should be reckoned with here and now, and the sooner the better!

Believe me or not, medicine is going through a renovating process, in most respects due to our own disregard and short sightedness. The old orthodox regime of medical attitude, ethics, policies, methods, etc., will be required to change or be subject to modification, just as things in general have done, oft' times not for the better, to say the least.

To disregard these facts will mean that we will have plenty of time to become expert bridge players, or what have you, but not by choice, however. Neither will it become necessary to consult a palmist about our future.

Medicine is being encroached upon from many sides, some of which are inevitable and detrimental to medicine in general. Insurance companies, various corporations, medical institutions, church organizations, etc., as well as city, state, and federal governments are in the practice of medicine right now. With this situation to contend with one can readily understand why great changes now and in the future are inevitable and apparent!

Let this sink in, please! There is one thing that no institution has or will ever be able to essentially replace with worthwhile thinking people, and that is: the personal relationship between the doctor and the patient, and don't you forget it! A great deal depends upon you as to whether or not you can establish a real personal relationship with the patient. (I did not say YOUR patient, for they don't belong to you or anyone else. You know that some trivial circumstance may arise which may disrupt a lifetime of undaunted loyalty and service to their welfare and best interests, all of which can be forgotten in a moment or two.)

Right here, it seems to me, it would be a matter of prudence to check up on our own shortcomings, both personal and professional. It is well to remember that the finest achievement in this life at least is to strive to elevate ones'self to that of being a first class human being and all that this implies. Better than a great scientist, artist, musician, or physician, is the one who has achieved this paramount success in life. This is the primary qualification for a successful career of any kind, not excepting medicine.

If you are the right kind of a human being and properly equipped, and by this I mean scientifically, practically, mentally, morally, as well as physically or anatomically able (not a biological mis-fit), then no institution can or will essentially replace you.

This is not a classic on sarcastic repartee—my sense of propriety I hope is too great for that—but let's be honest about things that mean so much to the welfare and well being of humanity and ourselves.

One thing the medical profession in general should realize and appreciate is that it is quite erroneous to think that when the legal right to practice medicine successfully is conferred that with it is conferred the natural intuition and ability to practice medicine scientifically and morally in a proper manner. It doesn't require very much grey matter or imagination to realize that brains, ability, honor, etc., can not be conferred by any institution. Men in other walks of life come to realize this. They are perhaps unsuited for the work they originally selected. Knowing this, they migrate from their original training ground to find their place in the great scheme of things. The reason for their leaving may be by force or embarrassment or down-right failure. It is not uncommon to find lawyers, architects, engineers, religionists, artists and the like seeking more appropriate fields of endeavor more suitable to their ability and make up, when they find they are out of their proper domain. Doctors rarely do this. The result is we have a field over crowded with those better suited for other fields of endeavor, both for their own good and humanity in general.

Did you ever realize how much more worthwhile a lawyer, legislator, religionist, etc., would be should he be the possessor of knowledge that only a medical education has to offer? Therefore, use your head, and if you find you are in the wrong environment or are unsuited for the practice of medicine and surgery, don't feel too badly about it. It may prove to be a blessing in disguise.

How often do we see a colleague more or less a biological misfit in the ranks, unable to "take it" in medicine and continue to struggle along making the best of it.

Department of Health and Public Welfare

NEWS ITEMS

RESPONSIBILITY FOR MEDICAL CARE:—With the definite trend in medical economics towards the payment of the medical man for all services rendered to individuals in his community, it is interesting to go into the history of the responsibility of communities for the care, both medical and otherwise, of the unfortunate poor.

The best article that we have seen on the subject is one which was printed some time ago in the official publication of the Nevada Board of Health. This article, which follows, states the method of procedure in Nevada, and it practically is identically the same as that followed in Manitoba with the exception that in our province the important statute which controls the responsibility for expenses is the section in the Municipal Act dealing with residence. In Manitoba the final decision as to residence insofar as it refers to hospitalization and medical care rests with the Minister of the Department of Health and Public Welfare and his decision is final.

"Settlements as Related to the Health Department.

Civilization has now reached the stage where humanity has decreed it to be the duty of the state to care for the sick and infirm.

Not so many years ago this function was attended to by either public or private charity. Such, however, is no longer the case. We are beginning to realize the truth, that we are our brother's keeper, and it is now considered no longer a charity, but rather a duty that the social organization owes to itself to protect its weaker members, and thus to strengthen itself, because it is self-evident that a chain is only as strong as its weakest link.

That this function of the state may not be abused, and that the expense attendant on this duty may be equitably borne, it has been necessary to pass much legislation to equalise the financial burden of caring for the weaker members of society.

Of course, if the afflicted persons are able to pay, they must do so, if not, the expense must be borne by the state, or city, or town of residence.

The determination of the liability of the municipal government for the support of those not able to support themselves, has given rise to the settlement laws.

A settlement is a legal residence enabling a person to claim maintenance, and imposing upon the state or city the duty of meeting the expense incurred by it, in caring for its sick or infirm.

For instance, if it becomes necessary to furnish medical aid to a person in Boston who is a resident of another town, the town of settlement must bear the expense incurred by this city in caring for the afflicted person.

Not infrequently the town of residence tries to avoid paying and this has led to a wide field of legislation to determine the right of the person to whom aid was furnished, and to determine who shall pay for that aid.

Under the early English laws before this function of the state was recognized, and where a person receiving state aid was branded as a pauper, this legislation was treated under the Poor Laws. Under Richard I and Henry the VII the duty was imposed upon parishes to care for the sick. Under Charles II and James II more legislation was passed in an attempt to determine what constituted a settlement.

In this country, as early as 1639, we find statutes pertaining to settled persons and unsettled persons. Settled persons were those who had settled in a town, and were entitled to a settlement. Unsettled persons were those who had no settlement. In 1659 a law was passed that if a person could not prove a settlement, the county was liable for his care. In 1767 a statute was passed that persons without settlements should be supported by the province. In this commonwealth legislation began in 1793, in regard to the poor, the sick, and infirm, and the original statute has been amended many times, down to today.

Since the founding of our government, the functions of the state have increased and expanded in every direction. Not the least of the state functions is the care of the health of its members. In every state in the Union, and in every city, town and hamlet there is a department of health, the special duty of which is to protect the health and lives of our citizens. A large proportion of the taxpayer's money throughout the country is spent through this department.

In all matters pertaining to communicable diseases the state's right is absolute and unconditional. It assumes the right and imposes the duty on the individual and on itself to regulate the conduct of all things pertaining to the public health. Assuming the right, or rather the duty, to protect the health of all its members, it may furnish such treatment as it sees fit, and may direct payment therefor, either from the individual or from the state funds.

Many persons are unable to meet the expense of such treatment, and in these cases the Settlement Law is appealed to, to determine who shall bear the expense.

The Health Department is concerned with Settlement Laws only as regards communicable diseases. In order that this law may be intelligently administered, old methods have been abandoned, and newer and more efficient means of handling this situation are now in vogue.

The first step, of course, is to render aid to the afflicted and safeguard the health of the general public. This is done through our hospitals and medical service.

If the case is a non-communicable disease, and the patient unable to pay, the matter is referred to the Department of Public Welfare.

If, however, the case is a communicable disease, payment of the bill for services rendered comes within the province of the Health Department, which must approve the bill before payment.

Such cases as tuberculosis, dog bites, eye trouble, diphtheria, scarlet and typhoid fevers, and the like, require immediate attention to protect the public, and the patient is entitled to, and receives medical aid from the city, regardless of who or how it shall be paid. There is an exception to this, however, where a patient not requiring immediate aid is to be sent to a sanitorium, in which case the settlement is generally determined before the patient is assigned to a hospital.

When the needs of the patients are taken care of, the question of liability for payment then arises, and this is where the Settlement Law applies.

Immediately after notice is received by the Health Department that a patient is being cared for, and that a claim will be made against the city for reimbursement, an investigation of this case is begun. The history of the patient is taken, checked, verified, or disapproved, and the bill is then approved or disapproved by the commissioner, and if approved, is presented to the city for payment.

If the bill is disapproved, because the evidence fails to establish a settlement, or shows a settlement elsewhere, the bill is then presented to the proper city or town. If no town of settlement can be found the matter is then presented to the state."

PROGRESS IN MEDICAL EDUCATION: The following is an abstract taken from an article written by Doctor W. J. Mayo of Rochester, Minnesota, which we think will prove of interest to the readers of the Manitoba Medical Association Bulletin:

"Proceedings of the Staff Meetings of The Mayo Clinic, Dec. 6, 1933.

When I entered the University of Michigan in the fall of 1880, Michigan had just established a medical course of three years of nine months each to replace the course of two years of four or five months each which was current in the United States. Up to that time, medical education in this country had been on the clinical basis. Even the fundamental branches of anatomy, physiology, and allied subjects were often taught by men in active practice, and the popular professors who stimulated the students were the great clinicians, for instance, Osler and Billings in medicine, and McBurney and Halsted in surgery.

In the University of Michigan the courses in chemistry, anatomy, and all kindred subjects were remarkably good for the time and the teaching was always closely connected with the clinical application. The patient was the center of the study, and day by day, as all the classes met in the clinical amphitheatre, even the freshmen in the back seats, too far back to see the details of the examination and possible operation, never lost sight of the object of medical education and absorbed, perhaps unconsciously, much clinical information.

While the leading clinical schools gradually improved their teaching methods, many schools continued the old methods until the epoch-making report of the Abraham Flexner Commission turned the spotlight on obsolete forms of medical education and brought in the academic as contrasted with the clinical method. Perhaps to some of us of the older school, it seemed that the academic side was over stressed. As the pendulum swung to didactic teaching, the great clinicians began to disappear, and with them went something of the thrill and romance of medicine to the medical students. Perhaps the development of the two-year premedical work which often has so little connection with medical practice, and the virtual separation of the first two years of medicine from its clinical application, had been too great a break. At least, the University of Minnesota felt that the medical students were not so well grounded as they should be in the actual practice of medicine, and in 1916 the University instituted the giving of the degree of Bachelor of Medicine at the end of the six-year combined course, and the degree of Doctor of Medicine after one year of hospital work. I hope the time will come soon when the hospital year can be made two years.

Far be it from me to attempt to give advice as to what the next generation is to do, but I wonder whether the present tendency to enter the specialties directly from the medical school without intervening conversion of knowledge into wisdom, making it effective. As I think back on my own classmates in college, I am impressed with the fact that many of them who had fine memories and stood at the heads of their classes, in some way in the after years missed acquiring wisdom and did not come up to our expectations. After all, the best the medical school can do is to give the students breadth of knowledge, not necessarily depth of knowledge. Some students can fill their minds with any given subject, book, chapter, and page, and can regurgitate this knowledge at examination and thereby win class leadership. Such memorizing of knowledge has not necessarily any relation to wisdom.

If the clinician knows three, four, or five important things about a disease condition, really knows them and they are true, he probably will do well in treating the disease, but if he knows too many unimportant things he may be lost in details, so that he will not properly recognize values; the two-cent pieces of information have a tendency to become mixed up with the twenty-dollar gold pieces of actual facts.

I sometimes wonder as I see our medical students work seven days a week and fourteen hours a day, largely in loading their memories with information, whether they have time to think, and I question whether it might not be better to give them a wide foundation that would make them excellent general practitioners and enable them to acquire further knowledge and greater usefulness as time goes on.

The specialist has great depth of knowledge, but the very excess of his knowledge in one department often narrows his vision. We need widely trained general practitioners who know the values of the important things in the breadth of the medical field. The patient cannot know what specialist to consult, and in many cases the specialist cannot obtain accurate knowledge of a particular case without the help of one who is widely versed in the conditions associated with the disease in question that are outside the limits of his expert knowledge.

Personally I have not been in sympathy with the view that because there are so many practitioners of medicine, something must be done to prevent younger men from entering our medical schools. It certainly is a sad commentary on our times if we introduce various obstructions and obstacles to prevent students from entering medicine or to trap unwary students, so that they may be prevented from continuing their studies after their course is started, unless such procedures result in turning out better practitioners and are not merely evidence of an unconscious trade-union state of mind which tends to make medicine an aristocracy.

If one considers the problem in the singular, one gets the idea that there are too many doctors, too many lawyers, nurses, grocers, coal-miners, and what not. As a matter of fact, it would appear that there are too many of all of us, yet that assumption of itself refutes the argument that we must reduce the number in each class. It is almost a paradox that when we have too much of everything collectively, we worry most because we have too little individually.

Think of the great number of people now in the hands of the irregular practitioners or taking patent medicines for conditions which the medical profession can relieve or cure. In the early day medical practice was individualistic and competitive, and lack of combined effort on the part of the profession furnished the broad highway by which the cults and the advertising patent medicine vendors reached the people. It is the duty as well as the privilege of the profession to reach this great reservoir of human derelicts who need help which only organized medicine is equipped to give them.

Perhaps if medical students could give more time to developing a sympathetic social understanding of what the people desire and are striving for, as physicians they would be more adequately prepared to acquire and deserve the confidence of the great mass of the people."

COMMUNICABLE DISEASES REPORTED — Urban and Rural — April, 1934. Occurring in the Municipalities of:—

Measles: Total 2484—Winnipeg 1950, Kildonan East 134, Kildonan West 65, St. Vital 50, St. Boniface 30, Blanchard 17, St. Paul East 16, Springfield 12, Tuxedo 11, St. James 7, Wallace 4, Lac du Bonnet 4, Fort Garry 4, Ethelbert 3, Brooklands 2, Cameron 2, Franklin 1, Harrison 1, Macdonald 1, Melita 1, Norfolk South 1, Selkirk 1, Silver Creek 1, Strathcona 1, Strathclair 1, Unorganized 1. (Late reported, January: Fort Garry 19; February: Fort Garry 11; March: Fort Garry 113, St. Boniface 20).

Whooping Cough: Total 95—Virden Town 31, Winnipeg 18, Dauphin Town 10, Unorganized 6, Eriksdale 4, Wallace 4, Hartney 2, Kildonan East 2, Kildonan West 2, Woodlea 2, Fort Garry 1, Westbourne 1. (Late reported, January: Boulton 1; March: Unorganized 11).

Chickenpox: Total 90—Winnipeg 36, Garson Village 12, St. Boniface 12, Silver Creek 7, Blanchard 4, Brooklands 3, Kildonan West 3, Norfolk North 3, Dauphin Town 2, Brandon 1, St. James 1, St. Vital 1. (Late reported, March: Brandon 3, Transcona 2).

Scarlet Fever: Total 66—Winnipeg 34, Kildonan Old 6, Grey 5, Kildonan West 4, Rockwood 3, Clanwilliam 2, Elton 2, Roblin Rural 2, Stonewall 2, Argyle 1, Hanover 1, Norfolk North 1, St. Boniface 1. (Late reported, March: Stonewall 2).

Tuberculosis: Total 36—Unorganized 3, Strathcona 2, Argyle 1, Bifrost 1, Brooklands 1, Flin Flon 1, Kildonan East 1, Kildonan West 1, Killarney Town 1, Oakland 1, Odanah 1, Portage Rural 1, Roblin Rural 1, Rockwood 1, Swan River Town 1, St. Andrews 1, The Pas 1, Turtle Mountain 1, Whitemouth 1.

Mumps: Total 30—Winnipeg 24, St. Boniface 3, Dauphin Town 1, Ste. Anne 1, Unorganized 1.

Diphtheria: Total 22—Winnipeg 11, Hanover 2, La Broquerie 1, Roland 1, Ste. Anne 1, Whitemouth 1. (Late reported, March: Rhineland 5).

Typhoid Fever: Total 14—DeSalaberry 5, Selkirk 2, Shoal Lake Rural 2, Winnipeg 2, Cartier 1, Cornwallis 1, Manitou 1.

Influenza: Total 10—Winnipeg 3. (Late reported, January: Brandon 1, Hartney 1, North Norfolk 2, South Norfolk 1, Unorganized 2).

Erysipelas: Total 7 — Winnipeg 3, La Broquerie 1, Morden 1, Shoal Lake Town 1, Silver Creek 1.

Trachoma: Total 5—Silver Creek 4, Kildonan East 1.

German Measles: Total 2—Kildonan West 1, Whitehead 1.

Septic Sore Throat: Total 2—Virden Town 2.

Puerperal Fever: Total 1—Dauphin Town 1.

Cerebrospinal Meningitis: Total 1 — Late reported, January: St. Andrews 1).

Paratyphoid: Total 1—Sifton 1.

Venereal Disease (Manitoba): Total 148—Gonorrhoea 103; Syphilis 45.

DEATHS FROM ALL CAUSES IN MANITOBA
for Month of February, 1934

URBAN — Cancer 29, Pneumonia (all forms) 12, Tuberculosis 8, Diphtheria 3, Influenza 3, Lethargic Encephalitis 2, Puerperal 1, all other causes under one year not included elsewhere 19, all other causes 104, Stillbirths 12. Total 193.

RURAL—Pneumonia (all forms) 23, Cancer 18, Tuberculosis 8, Influenza 3, Whooping Cough 2, Chicken Pox 1, Diphtheria 1, other causes under one year not included elsewhere 17, all others 110, Stillbirths 13. Total 196.

INDIANS — Tuberculosis 8, Whooping Cough 6, Pneumonia (all forms) 4, Influenza 1, other causes under one year not included elsewhere 6, all others 4. Total 29.

THE MOST NORTHERLY DOCTOR

North of Ungava, across Hudson Strait, past Frobisher Bay and Cumberland Sound—at Panguirtung in barren Baffin Island Leslie David Livingstone, M.D., "hangs out his shingle." He keeps no office hours and has no schedule of fees. He goes looking for his patients eight hundred miles, eleven hundred miles, it's all the same to him. With twelve powerful huskies hauling his komitik he carries the white man's art of healing to Canada's igloo dwellers in Baffin Island and ministers also to the medical needs of Canada's administrators of that vast area, the red coated police, traders, trading post factors and missionaries. His visits to civilization are only occasional.—"The Queen's Review," March, 1934.

SUMMER DIARRHEA IN BABIES

Casec (calcium caseinate), which is almost wholly a combination protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with 8 level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six tablespoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. Please send for samples to Mead Johnson & Company, Evansville, Indiana. —Adv.

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

THE CANADIAN MEDICAL ASSOCIATION JOURNAL
April, 1934.

"Carcinoma of the Stomach" — by Roscoe R. Graham, M.B., F.R.C.S. (C.), Toronto.

—An excellent article on this subject, urging more careful investigation of cases of indigestion and earlier and more radical surgical treatment.

"Sterility in the Female" — by W. F. Abbott, B.A., M.D., C.M.

—A complete survey of the subject.

"Problem of the Squinting Child" — by Louis Kazdan, M.B., Toronto.

"Rumination: With Report of Two Cases"—by L. J. Notkin, Montreal.

—Rumination is described as a usually inherited, or more rarely, acquired ability to regurgitate, re-chew and re-swallow the food partaken of.

"A Case of Hyperparathyroidism Associated with Hyperthyroidism" — by E. H. Wood, M.B., F.A.C.S., Ottawa.

"Staphylococcic Infections in Diabetes Mellitus, with Special Reference to the Use of Staphylococcic Toxoid"—by Jos H. Gilchrist, B.A., M.B., and Mary J. Wilson, Toronto.

—A preliminary report on the use of staphylococcal toxoid in diabetics. The authors believe there is a distinct staphylococcic factor in the etiology of the disease, and that by using toxoid they are attacking the cause. Insulin dosage could be decreased when the toxoid was used.

"Tumors of the Heart: Histopathological and Clinical Study" — by Ross M. Lumburner, M.D., Fellow in Medicine, The Mayo Foundation, Rochester, Minn.

THE PRACTITIONER—April, 1934.

This number contains a symposium on "Gastro-Intestinal Disorders." No. 2 — Dyspepsia.

"The Surgical Aspects of Dyspepsia"—by D. P. D. Wilkie, O.B.E., M.D., M.Ch., F.R.C.S.

"Flatulent Dyspepsia — Its Causes and Treatment"—by John Henderson, M.D., Ch.B.

"Some Chronic Mild Digestive Disorders in Children" — by C. Paget La Page, M.D., F.R.C.P.

"The Meaning of the Mobility of the Viscera"—by Alfred E. Barclay, O.B.E., M.D., D.M.R.E.

The following additional articles are found in the same number:—

"On Gull's Disease (Spontaneous Myxœdema of the Adult)"—by Llewellyn F. Barker, M.D.

"Some Aspects of Eneuresis"—by Wilfred Sheldon, M.D., F.R.C.P.

"Euthanasia"—by T. E. Hammond, F.R.C.S.

"The Value of Auscultation of the Acute Abdomen"—by T. G. Illtyd James, M.Ch., F.R.C.S.

"A Plea for the Neurotic" — by J. W. Astley Cooper, F.R.C.S., L.R.C.P.

ANNALS OF SURGERY—May, 1934.

"Tuberculosis of the Breast"—by Walter Estell Lee, M.D., and W. Russell Floyd, M.D., Philadelphia.

—A good discussion of the clinical and pathological findngs in this condition.

THE BRITISH JOURNAL OF SURGERY
April, 1934.

"Multiple Carcinoma of the Colon: With Four Original Cases" — by A. J. Cokkinis, St. Mary's Hospital, London.

—This author points out that multiple primary malignant growths occur more frequently than can be accounted for by coincidence. They are attributed to multiple or diffuse precancerous lesions, or to an individual susceptibility to malignant disease. It is also suggested that study of such conditions may shed light on some of the unsolved problems of cancer pathology.

"Neurosurgery in the Treatment of Diseases of the Peripheral Blood-Vessels" — by D. J. MacMyn, Rochester, Minn.

—This paper deals mainly with Thrombo Angritis Obliterous and Raynaud's Disease.

"The Plan of the Visceral Nerves in the Lumbar and Sacral Outflows of the Autonomic Nervous System" — by Hugh C. Trimble, Melbourne, Australia.

—An anatomical study of this system.

THE CLINICAL JOURNAL—March, 1934.

"Major Surgical Regrets in Gynæcology and Obstetrics"—by V. B. Green-Armytage, West London Hospital.

—A post-graduate lecture.

"Prostatic Obstructions: Modern Methods of Treatment"—by E. W. Richer, London.

"Puerperal Peritonitis"—by L. N. Pyrah, F.R.C.S. (Eng.), and C. Oldfield, F.R.C.P., F.R.C.S., Leeds, England.

"Carcinoma of the Lung" — by Reginald Ellis, M.D., M.R.C.P., Manchester.

"Common Upper Respiratory Infections in Childhood" — by K. H. Tallerman, M.R.C.P., London.

THE NEW ENGLAND JOURNAL OF MEDICINE
May 3rd, 1934.

"Acute Thyroiditis with Report of Ten Cases"—by Robert C. Cochrane, M.D., and Stanley J. G. Novak, M.D., Boston.

"Carcinoma of the Small Intestine"—by Horace K. Sowles, M.D., Boston.

"Excision of the Thoracic Oesophagous for Carcinoma, with Construction of an Extra Thoracic Gullet"—by George Grey Turner, M.S., Newcastle, England.

"The Prevention of Crime: The Gangster in the Making"—by L. Vernon Briggs, M.D.

—From a paper read before the New England Society of Psychiatry, October, 1933.

News --- Notes --- Correspondence

WILLIAM DUNLOP
1792-1848
By Colonel F. S. L. Ford, C.M.G., M.D.

By ROSS MITCHELL

COLONEL FORD, known to many of our readers as the able Director of Medical Services of the Canadian Expeditionary Force, has proved his versatility in this vivid sketch of a virile character, 'Tiger' Dunlop. Read before the Academy of Medicine, Toronto, on January 6th, 1931, and published in the "Canadian Medical Association Journal," August, 1931, this sketch is now issued in an attractive brochure by the Albert Britnell Book Shop, 765 Yonge Street, Toronto. The dedication is to the late Colonel John Stewart of Halifax, and, with other illustrations, there is a reproduction of the fine drawing by Maclise in "Fraser's Magazine," 1833. The length of the bibliography attests Col. Ford's wide research.

Born at Greenock in 1792, William Dunlop received a sound education as befitted one of a family boasting many university professors and in 1813 he became Assistant Surgeon to the 89th Regiment which sailed for Canada in August of that year to engage in "Mr. Madison's War." He attended the wounded at the battles of Chrysler's Farm, Lundy's Lane and the assault on Fort Erie where he carried out of the firing line on his back, 'like sacks of potatoes' ten or a dozen wounded men. How capable he was of such a feat may be judged from the description of him in "Fraser's Magazine," nineteen years later: "This remarkable biped, who is now in London for a few weeks to worry Goderich and Howick about some beastly proceedings of our degraded government, stands six feet three inches—and measures two feet eight across the shoulders; in the graphic language of Rimini Unt:—

> 'Lightsomely drops in his
> lordly back';

the calf is just twenty inches in circumference — ex pede Herculem; the paw would have startled Ali Pacha; the fur is of the genuine Caledonian redness and roughness; and the hide, from long exposure to Eurus and Boreas, has acquired such a firmness of texture, that he shaves with a brickbat. . . . . Farewell, noble savage, wild as thy woods. When shall we again revel in the rich luxuriance of thy anecdotes—or shake under the Titanic bray of thy laughter?'

The close of the war in Canada brought the 89th Regt. back to England too late to participate in the battle of Waterloo. Eighteen months later he went with the regiment to India where he remained till 1820, gaining the nickname of 'Tiger' from his exploits in clearing the island of Saugar, in the Ganges, of a number of man-eating tigers. Broken in health by jungle fever he returned to Edinburgh where he lectured at the University on medical jurisprudence, wrote sketches of life in the Orient for several magazines, and became the associate of such men as Lockhart, the biographer of Sir Walter Scott and of Christopher North of the 'Noctes Ambrosianae.'

In 1826 he was chosen by John Galt, then Superintendent of The Canada Company to accompany him to Canada as his right hand, with the title 'Warden of the Forests.' Dunlop assisted in the laying out of the 'Huron Tract' and took part in the ceremony of felling the giant maple tree which marked the founding of the city of Guelph, April 23, 1827. With his brother, Capt. Robert Dunlop, R.N. retired, he built Gairbraid House in Colborne across the river from Goderich with its mahogany table, heavy chairs and the celebrated liquor traveller with the famous 'Twelve Apostles.' In the rebellion of 1837 the Doctor headed the loyal 1st Huron Regiment and distinguished himself by his zeal for the welfare of his men. He succeeded his brother

as member for Huron in the Upper Canada Legislature from 1841 to 1846, resigning when he became superintendent of the Lachine Canal, a post he held until his death two years later. His remains rest with those of his brother on their Gairbraid estate on the Maitland River.

Colonel Ford has drawn an engaging picture of this rugged Scot, who, cast in heroic mould for all his foibles and eccentricities, deserves recognition from the country of his adoption which he served so faithfully.

SPECULATION

By

A. W. MACKINNON

SPECULATION is one of the greatest forces in modern life. It is so all embracing that no one understands it. Like hope, it adds zest to life. Like hope that is well founded, speculation can be well founded, and like hope that is not justified so many a speculation has not been justified.

We hear a great deal nowadays about curbing speculation, but can it be curbed and will the business community not be worse off if it is? It is speculation alone which makes a market when trade slackens. Where there is a good supply of speculation in a market, that security or commodity can always be the more easily bought or sold and general business is speeded up, but where no speculation exists a bona fide buyer or seller must be found and he will probably hold out for his price, thus slowing up all activity. "Where there is life there is hope" is an old adage and it might be said that where there is hope there is life. Certainly it may be said that where there is business there is speculation, and where there is no speculation there is little business.

Marginal trading in stocks and commodities has been attacked on all sides, but is the attack justified? Would the medical profession be doing its whole duty today if its personnel demanded cash before treatment in all cases? Would there be many home owners or home builders were we all required to pay outright spot cash before we could own or build a home? Would there be one-half the motor cars in our cities and towns, or would there be in virtual fact any great settlement of people in Western Canada were we all required to pay spot cash for everything we own or use before we could feel that thrilling right of possession? The answer is the credit structure. If we are prepared to admit that no credit should be given to anyone for any purpose whatever, then we can prove that it is wrong to buy or sell a security or commodity on margin.

If we accept, then, the right of the individual to speculate, and let it be known that it must be with his own money, what then are the essentials from the speculator's point of view?

1. **The broker.** Is the broker fully licensed? Is his financial standing sufficient to protect your equity? Is he or his staff experienced? Does he call all his clients to margin each and every time a call is required and is he sufficiently considerate of his clients who do answer margin calls that he will immediately sell out those who do not? Has he the facilities necessary to give you satisfactory information in regard to any contemplated commitment? Has he anything to sell except his service?

2. **The stock.** Can you as the client afford to lose any or all the margin deposited on the stock? Is the stock volatile, that is, are the fluctuations sharp and severe? What if any dividends are paid? If dividends are paid, when are the meetings held for dividend action? Is the commitment being made with a view to taking a quick profit, or is it for long term appreciation, and what is the objective in each case?

Now, from the point of view of the broker.

1. **The client.** Is he a reliable citizen? Has he a sufficient regard for his equity to take some pains to protect it by answering his calls promptly should the occasion arise, or is he one of those misinformed hopefuls who thinks that the onus of calling margins rests with the broker? Has he a mind of his own or is he subject to the wiles of tipsters? Is he near at hand should a call suddenly become necessary.

2. **The stock.** Is the stock listed? Does it enjoy a broad and active market? Is it subject to violent fluctuations and is the margin sufficient to protect him from losing his own money should the client be so careless as to leave it to "George?" Is the order large enough to pay for the cost of opening an account? Can

he afford to finance the unpaid balance of the security in the event his banker refuses to lend the broker any money on it?

And now a few hints on speculative trading may not be untimely for those who are satisfied that speculation is not a crime.

Do not over trade. Do not be afraid to take a loss. There can be only one motive for buying any security or commodity. That is that you are satisfied it cannot be purchased at a lower figure, and that it will either give you a very satisfactory return on your money or will appreciate in value to the point where it can be sold at a satisfactory profit. Conversely, there can be only one motive for selling a security or commodity. If, after a commitment has been made and you find that you were wrong in your judgment, do not procrastinate. Do not say I cannot sell that yet or I will have a loss in it. Remember that the loss is there anyway. Let each day stand on its own footing, and if today you regret your action of yesterday to the point of losing the confidence you had when you made your commitment, be man enough to admit you were wrong and correct it as quickly as possible. Do not be afraid to take a loss and do not be too greedy to take a profit. Let the man who buys from you have a chance to make a little on the deal or no one will make any profits at all, for it is generally true, if not literally true, that only one man buys at the bottom and only one sells at the top. Remember that your broker is willing and anxious for you to profit, for only on satisfied clients can he hope to establish his business, which is as honourable and necessary as any in our modern life, and remember also that the speculator is the man who makes the trade possible whether you want to buy or sell.

—Advt.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

At a recent meeting of the Council of the College of Physicians and Surgeons of Manitoba the following motion was passed, namely:

"That when a member of the College of Physicians and Surgeons of Manitoba becomes Sixty-Five (65) years of age, and has practiced Thirty (30) consecutive years in the Province of Manitoba, and is in good standing, that his name be enrolled as a Life Member of the said College."

Would any member who considers he is within this status kindly notify the Registrar?

MANITOBA MEDICAL ASSOCIATION

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ANNUAL MEETING

WINNIPEG

SEPT. 10-11-12

1934